Recommendation 4: Two (2) access center pilot projects should be established in dispersed geographic locations by the end of SFY19.

Access centers should provide immediate, short-term assessment and treatment services to individuals that do not require inpatient psychiatric hospital level of care, but need significant amounts of support and services not available in the individual's home or other available community-based setting.

Access centers should:

- Serve individuals cleared and referred by the hospital emergency department on a no eject/no reject basis and accept others not from the emergency department if the access center determines it can safely serve them;
- Provide mental health and substance use disorder assessments by appropriately licensed/credentialed professionals;
- Use the assessment to develop and initially implement an individualized person-centered plan;
- Provide or arrange to provide immediately needed mental health and substance use disorder treatment;
- Provide or arrange to provide withdrawal management services as needed;
- Provide or arrange to provide necessary physical health services;
- Provide crisis stabilization residential services;
- Provide subacute services;
- Provide Peer Support services;
- Provide linkages to needed services such as housing, employment, shelters, etc.; and
- Provide care coordination that provides individuals successful navigation and warm handoffs to the next service provider.

Note: There was discussion about access centers functioning as mental health emergency departments with direct access similar to hospital emergency departments. Advantages of this include: everyone knows where to go in every instance and all incidents related to mental health are diverted from the hospital emergency department. Disadvantages include serving individuals in a non-physical health setting that are not medically cleared. An alternative is to have access centers in hospitals (e.g., the Rock Island model) or have physical health care providers available to access centers to do physical health clearance.

MCOs and the MHDS Regions should jointly select two pilot access centers in strategically located areas of the state.

MHDS Regions should provide start-up funds for the establishment of the jointly selected access centers.

MCOs should reimburse the jointly selected access centers at the floor rate for covered Medicaid services provided by the access centers that the centers are enrolled to provide to

MCO members that have a demonstrable need for the service. MCOs should offer jointly selected access centers contracts to provide Medicaid reimbursable services.

MHDS Regions should be required to provide additional funding for non-Medicaid services necessary to keep efficiently and effectively operated access centers financially viable (e.g., pay for non-Medicaid services that may be needed like room, board, transportation, and reasonable operational vacancies).

The number of subacute beds funded from Medicaid should be increased significantly beyond the current 75 beds in Iowa Code 135G.